Temporary Permit Form

KRS 311.575 provides that Temporary permits may be issued **at the discretion of the Executive Director**, provided the applicant for a full license has a **completed application with all supporting documents** on file with the Board, meets all statutory requirements for licensure, and needs to begin working in Kentucky before the next regularly scheduled meeting of the Board. ***You must request the Temporary Permit by completing this form; it is not automatically issued.***

Temporary Permits will not be issued to an applicant who has a prior history of disciplinary action taken by a licensing jurisdiction or hospital, a criminal record, a history of substance/chemical abuse or any negative or derogatory information. This also includes any malpractice cases in the last ten years in which you paid a settlement of $100,000 or more.

The Temporary Permit will not be issued until all administrative screening processes are complete including the FCVS Profile. Do Not make any commitments prematurely. The Board recommends that you do not make any commitments to accept a position in Kentucky until you have a Temporary Permit *in hand*.

You may request a Temporary Permit by completing this form and returning it directly to the Board:

Name: _____, M.D./D.O.
(please print)

Practice Location in Kentucky: _____

_____

Date Temporary Permit Requested: _____

Address Temporary Permit should be mailed: _____

_____

Please Note: You will not be issued a Temporary Permit to practice in Kentucky without a specific Kentucky practice address listed on this form.

Kentucky Board of Medical Licensure

310 Whittington Parkway Suite 1B
Louisville, KY 40222
(502) 429-8046

Complete this form only if you answered "yes" to Category I, Question #15. This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement. Your application is not complete until this form has been returned to the Board.

_____

Name of Physician *Office Telephone No.*

_____

Address *City* *State* *Zip*

***Malpractice Complaint**: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)*

Patient's Name: _____

Age: _____ *Sex:* _____

Date/Place of Occurrence: _____

Indicate you position in case, i.e., resident, primary physician, etc: _____

_____

Filed Against: *( ) Individual Doctor ( ) Group ( ) Hospital*

List names of other defendant-doctors and/or hospitals: _____

_____

Disposition: *( ) Pending ( ) Jury Verdict ( ) Settled*

If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Date: _____ *Total Amount Paid (if any):* _____

Amount attributable to you: _____

Send To This Board Copies Of The Complaint, Answer, Release, Settlement Documents, All Other Relevant Legal Documents.

On A Separate Sheet, Please Provide A Detailed Explanation Of Background And Medical Issues Involved In The Case.

Signature: _____ *Date:* _____

→ *A separate report must be completed for each malpractice suit. This form may be duplicated. Please return form(s) and other information to the Board at the above address.*

Form 1

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Verification of Licensure

To Applicant: In applying for a license to practice medicine/osteopathy in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires **each** state or Canadian province where you **currently hold or have ever held** a medical license complete this form. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name of Applicant: _____M.D./D.O. License No:_____
(Please print)

Address:_____

_____M.D./D.O.
(Signature)

****

To Reference Source: Please complete this form, sign, seal and return directly to the Board (KBML) at the above stated address. Any fees for completion of this form should be collected from the physician. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

• • • Please Type or Print All Information • • •

State of:_____License No:_____

Issue Date:_____ Expiration Date:_____

Basis for Licensure:_____

Current Status:_____

Limitations: _____

Derogatory:_____

_____

Signed: _____

Board Seal

Title: _____

Form 2

Physicians Name _____M.D. / D.O.

List all hospitals, clinics, etc., other than training where you have practiced medicine within the last five (5) years <u>and send Form 2A to each</u>. *(This should also include moonlighting, administrative, and all locum tenens assignments.)*

Dates **(From – To)**	Hospital/Clinic/Office Name	Complete Address	**Indicate Locum Tenens, Moonlighting or Type of Privileges**

Form 2A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name:_____M.D./D.O. _____
(Please print) (Signature)

Name and Address of Facility:_____

****

To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. Position and Department of the above applicant?_____
2. Affiliation Dates: From _____To _____
3. Were any limitations imposed on this physician?_____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action._____
   _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined?____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action. _____
   _____
5. Was the above physician terminated from employment? _____ If yes, please explain in detail.

   Derogatory Information, if any:_____

   Comments, if any:_____

Signature, Date, Title _____

Printed Name _____

Facility _____

Affix Seal Here

Address _____

(If no seal, so indicate)

_____

Phone Number _____

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source ***directly*** to the Board at the above address.

In addition, the forms must meet the following criteria:

(a) Recent (no older than 6 months)
(b) Original signature
(c) Sent by licensed physician familiar with your practice. It is preferable that one be sent by the Program Director for those who recently completed residency training, or the last hospital where staff privileges were held.

Please be sure to indicate your name below for identification purposes.

Name of applicant:_____
(Please print)

****

To reference source: Please complete this form, sign and return directly to the Board at the above stated address. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

From: _____
(Full Name – Please Print)

_____
(Address) (City, State, Zipcode)

Telephone: (_____) _____

1. How long have you known the applicant? _____

2. In what capacity are you acquainted with him/her? _____

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☐	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☐	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☐	☐

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☐	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☐	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☐	☐	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☐	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☐	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☐	☐	☐
12.	Are you sorry to see this physician leave your community?	☐	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☐	☐	☐

Comments: _____

_____

_____

Signature and Date _____

Title _____

Printed Name _____

Telephone Number _____

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source to the Board at the above address.

In addition, the forms must meet the following criteria:

(a) Recent (no older than 6 months)
(b) Original signature
(c) Sent by licensed physician familiar with your practice. It is preferable that one be sent by the Program Director for those who recently completed residency training, or the last hospital where staff privileges were held.

Please be sure to indicate your name below for identification purposes.

Name of applicant:_____
(Please print)

****

To reference source: Please complete this form, sign and return directly to the Board at the above stated address. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

From: _____
(Full Name – Please Print)

_____
(Address) (City, State, Zipcode)

Telephone: (_____) _____

1. How long have you known the applicant? _____

2. In what capacity are you acquainted with him/her? _____

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☐	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☐	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☐	☐

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☐	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☐	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☐	☐	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☐	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☐	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☐	☐	☐
12.	Are you sorry to see this physician leave community	☐	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☐	☐	☐

Comments: _____

_____

_____

Signature and Date _____

Title _____

Printed Name _____

Telephone Number _____

Form 4

Release and Waiver of Rights Form

I, _____, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All medical/osteopathic schools that I have attended.

2. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.

3. All medical/osteopathic societies, specialty boards, and other medical/osteopathic organizations with which I have been associated.

4. All other state or Canadian licensure boards, federal health agencies, and federal and state drug control agencies.

5. All licensed physicians, nurses or other health care professionals of any state or Canadian province.

6. All attorneys who have participated in civil or criminal actions in which I was named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me, which is relevant to the requirements for licensure. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for a license to practice medicine/osteopathy in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued licensure.

This release and waiver of rights has no expiration date and shall remain effective during my licensure in the Commonwealth of Kentucky.

_____

(Applicant's Signature) (Date)

_____

(Print Name)

Sworn to and Subscribed Before Me By the Above Named Applicant on this the ___day of _____, 20 ____.

Seal

_____

Notary Public

My Commission expires:_____

Form 5

National Practitioner Data Bank

The National Practitioner Data Bank is a National Data Bank that collects information from all state medical boards and healthcare facilities.

You will need to complete the form for a self-query report on their website:

www.npdb-hipdb.com

This form, once completed on their website, should be mailed directly to the data bank:

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

The National Practitioner Data Bank will process the reports and **mail them directly back to you**. Once you receive the reports, you must **forward the originals** to the Board.

Please note, you will receive two reports. Be sure to mail all documents received to the Board.

Form 6

AMA/AOA Physician Profiles

AMA Profile – ***To be completed by all allopathic medical school graduates. Including International medical graduates.***

A ***Physician Profile Request*** must be ordered directly from the AMA website. Members and non-members of the American Medical Association must complete this form. You must complete the profile on-line and the AMA will forward your profile request directly to the **Board**:

www.ama.assn/org/AMAPhysicianProfiles

For questions or any problems with their website, please contact the AMA directly (312) 464-5000.

AOA Profile – ***To be completed by all osteopathic medical school graduates only***

A Physican Profile Request must be ordered directly from the AOA website. Members and non-members of the American Osteopathic Association must complete this form. You must complete the profile on-line and the AOA will forward your profile request directly to the **Board**:

www.aoa-net.org/ProductsServices/services.htm

For questions or any problems with this website, please contact the AOA directly (312) 280-5800.

Form 7

Kentucky HIV/AIDS Education
Affidavit of Reasonable Cause

I, _____, request that the Board (KBML) defer my
(Name)

HIV/AIDS education requirement for initial professional licensure (KRS 214.615) for the following reason,

Please explain in detail: _____

_____

_____

I understand that the deferment is valid for six (6) months from the date of the issuance of my temporary permit to practice medicine and is **not renewable.** I further understand that within this six months I must send to the Board (KBML), a copy of a certificate showing completion of a Kentucky Cabinet for Health Services approved HIV/AIDS course for a full and unrestricted license to be issued.

Signature: _____ Date: _____

Printed Name: _____

Social Security Number: _____

→ This form must be sent to the Board (KBML) in order for you to receive a six-month extension. Please retain a copy of this affidavit for your records. Either this affidavit or the completed course must be in the Boards office in order to meet the Board Deadlines. **A list of approved courses may be obtained from the following website: http://chfs.ky.gov/dph/hivaids.htm or by calling (502) 564-6539.**

Mail this form to the following address:

Medical Licensure Coordinator
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-8046

Kentucky Board of Medical Licensure
HIV/AIDS Education Certificate Requirements

During the 1990 regular legislative session, the General Assembly passed House Bill 425, which mandated Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) education requirements for health professionals. Further, the General Assembly mandated that the Cabinet for Health Services (CHS) administers this program and that the Kentucky Board of Medical Licensure monitor compliance.

On or after September 24, 1991, all applicants for medical licensure must comply with the two (2) hour AIDS education requirement.

Prior to receiving a Kentucky medical license, each applicant for licensure must submit to the Kentucky Board of Medical Licensure one of the following:

- A copy of a certificate of completion of an approved course. The AIDS course (2 hours minimum) must be included on the official listing of approved courses maintained by the Cabinet for Health Services, and the CHS approval number must appear on the certificate. **Certificates without a CHS approval number will not be accepted.**

- An "Affidavit of Reasonable Cause" form if the requirement is not met prior to temporary licensure. If the AIDS course is not completed by the time a temporary license is to be issued, the applicant must complete an "Affidavit of Reasonable Cause" form to verify that the requirement will be met within the next six (6) months. This affidavit shall be valid for no more than six (6) months and is not renewable. Eligible applicants will be issued a Temporary Permit only for this six (6) month period. The full license to practice medicine in Kentucky will not be issued until this requirement is met.

- If an applicant has graduated from a medical/osteopathic school, whose AIDS education is approved by CHS, within five (5) years and has been in a residency program throughout the interim, the applicant shall be deemed to have met this requirement. **Contact the AIDS Education Program at CHS to see if your medical school curriculum has been approved**. (See below)

If you have any questions regarding applicable courses, approval of courses, or if you need **to obtain a listing of approved courses,** please contact:

http://chfs.ky.gov/dph/hivaids.htm

AIDS Education Program
Cabinet for Health Services
275 East Main Street
Frankfort, KY 40621
(502) 564-6539

Form 8

CME Form

Name_____
(Please Print or Type)

Record of Category I Continuing Medical Education Credits(Last 3 years)

DO NOT PROVIDE DOCUMENTATION

Dates:	**Name of Activity/Course**	**# of Credit Hours**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I attest that the above is valid.

_____ _____

Signature **Date**

Form 9

Kentucky Board of Medical Licensure
Criminal Background Requirements

KRS 311.565

This notice should be provided to all applicants applying for a full-unrestricted Medical/Osteopathic License in the Commonwealth of Kentucky by endorsement.

All persons applying for a Kentucky Medical License on and after August 15, 2003 shall submit proof of a FBI Criminal Background Check to the Board as a part of the application for a license to practice medicine in the Commonwealth. This record must indicate that there have been no felony convictions or pending charges at any time or any misdemeanor convictions or pending charges within the previous five-year period. Some examples of misdemeanors which will be subject to a Board investigation include: DUI, sexual assault, certain theft charges, and drug convictions. In general, speeding and minor traffic violations would not be misdemeanors. Some serious traffic violations could be misdemeanors.

Where can I obtain the necessary FBI forms? To obtain the fingerprint cards, check with your local law enforcement agency (any state), the Kentucky State Police (check www.kentuckystatepolice.org/post.htm for the nearest location), or call the Federal Bureau of Investigation, Criminal Justice Information Services Division at 304-625-3878. You must listen to the Entire recording and request the cards to be sent to you at the very end. You will receive two fingerprint cards in the mail within 3 – 5 days.

Who will take my fingerprints? Most local law enforcement agencies, county sheriff's departments, and some city and county police departments, or any state police post may be able to take your fingerprints. The law enforcement agencies will be taking your fingerprints for a **Personal Review**. Some law enforcement agencies may charge a fee for fingerprinting services. The cost may vary.

What is the cost and where do I send it? Send the completed fingerprint card, a short letter (A sample letter is attached for your review) advising the FBI that the report is desired for personal review, and a certified check or money order, payable to the Treasury of the United States, in the amount of $18 to the address listed below. **If all items are not included, the request will be returned to you by the FBI for correction.**

Federal Bureau of Investigation
Criminal Justice Information Services Section
Attn: Records Request
1000 Custer Hollow Road
Clarksburg, WV 26306

What if my report comes back indicating that the prints are unreadable or indiscernible? If a criminal background report comes back from the FBI indicating that the prints are indiscernible or unreadable, the applicant should have the second set of prints done at the nearest State Police Post and resubmitted to the FBI for processing. If the second report comes back with the same result, then the Board has an affidavit that the applicant can sign before a notary to use for the issuance of a license. All of the **original fingerprint cards and reports** must be submitted along with the affidavit in order for the affidavit to be valid. If the applicant goes to the State Police Post first and that report comes back unacceptable, then he/she must have the prints done at one other location. Thus, no license will be issued to the applicant (using an affidavit) unless there have been at least two FBI reports obtained that indicate a failure to read the prints, one of which resulted in the fingerprints being done by the State Police Post.

Also, we cannot accept a copy of a report that has been done for any other entity or organization. Applicants must have their prints taken and forwarded to the FBI for processing. The original fingerprint card(s) and report(s) must be submitted to our office for processing your application for a medical license.

How long does this process take and how long is the report valid? Approximately **4-6 weeks**, upon submission of the fingerprint card to the FBI. Thus, you should apply for the criminal background report at the time that you submit your application for licensure to the Board. **The report is only valid for one year.**

What should I do if my report is clear? The report will be mailed directly to you. The **original** report(s) and fingerprint card(s) must be submitted for completion of your application for a medical license. Photocopies of the fingerprint card and/or the written report from the FBI are not acceptable.

What happens if I have a conviction or pending charges? You must submit the criminal background report to the Board within five days of receipt of the FBI identification record. The Board will then begin an investigation into the conviction or charges. Just a reminder, you will be asked about any presently pending and/or prior convictions of felonies or misdemeanors on the Board's application for licensure, please be sure to answer these questions in a truthful manner.

If a conviction is noted, how long will the Board's investigation process take? Approximately 60-90 days depending upon how quickly all the documents are returned to the Board and the backlog of cases.

IMPORTANT NOTE: The Board **will not** issue a Medical License to you until we have received the final fingerprint card(s) and background report(s).

If you have further questions, please contact the Board's office between 8:00 a.m. and 12:30 p.m., EST, at (502) 429-8046, Ext. 222.

Kentucky Board of Medical Licensure
Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Federal Bureau of Investigation
Criminal Justice Information Services Division
1000 Custer Hollow Road
Clarksburg, WV 26306

RE: CRIMINAL BACKGROUND CHECK

I am requesting this background check and report for a personal review. Enclosed is the required, completed fingerprint card, along with the $18 processing fee. (Certified check or money order, payable to: Treasury of the United States).

PLEASE RETURN THE REPORT TO ME AT THE FOLLOWING ADDRESS:

Printed or Typed: _____
Full Legal Name

_____
Street Address

_____
City, State, Zip Code

_____
Signature

_____
Date